# Answers to your questions about utilization review

Utilization review is the program employers or insurance companies use to make sure treatment given to injured workers is consistent with medical treatment guidelines set by the state.

All employers or the insurance companies handling their workers' compensation claims are required by law to have a utilization review program. This program will be used to decide whether or not to approve medical treatment recommended by your doctor.

**Q: What are the medical treatment guidelines set by the state?**
A: Treatment guidelines lay out treatments scientifically proven to cure or relieve work-related injuries and illnesses. They also deal with how often the treatment is given and for how long, among other things. The state of California is currently using the American College of Occupational and Environmental Medicine's (ACOEM) Practice Guidelines, Second Edition.

**Q: Where can I look at the ACOEM guidelines?**
A: Copies of the ACOEM guidelines are available for review at your local Workers' Compensation Appeals Board (WCAB) office. The ACOEM guidelines are also available at many law, university and public libraries.

**Q: What if the treatment my doctor recommends isn't in the ACOEM guidelines?**
A: Your doctor needs to use other scientifically-based medical treatment guidelines generally accepted by the national medical community to support the recommended treatment.

**Q: I was awarded future medical treatment for my work injury. I have a copy of the award. Does utilization review apply to me?**
A: Yes. The law requiring utilization review went into effect Jan. 1. 2004 and it applies to all medical treatment being given, even if you received your award before Jan. 1, 2004.

**Q: Who can evaluate the medical treatment my doctor has recommended?**
A: Anyone handling claims can **approve** the treatment recommended by your doctor. However, a decision to **deny** or **change** your treatment can only be made by a physician who understands the type of injury or illness you have and the treatment being recommended.

**Q: What happens when my doctor recommends treatment and the insurance company does a utilization review?**
A: The insurance company must do the review and make a decision within five days of the date your doctor requested the treatment. If it needs more time, the insurance company can have up to 14 days. This is called "prospective review" because it's done before you get the treatment.

**Q: What if my doctor has already provided the treatment and the insurance company does a utilization review?**
A: The review must be done and the decision given to your doctor within 30 days. This is called a "retrospective review".

**Q: What happens if I got treated and the insurance company says they won't pay for it? Do I have to pay?**
A: Most likely, no. This is a problem your doctor and the insurance company need to work out.

**Q: What if my doctor requests treatment while I am in the hospital?**
A: Unless your doctor requests an "expedited review", the review process and timeframe is the same as in the "prospective review". This is called "concurrent review" because the review is being done while you're receiving treatment.

**Q: What is an expedited review?**
A: This happens when your doctor recommends treatment and says you face a serious threat to your health if you don't receive it. That could mean possible loss of life, limb or other major bodily function. It could also mean the normal time frame for a decision could harm your life or health, or could permanently risk your ability to recover to the fullest.

**Q: How long does an expedited review take?**
A: The insurance company has 72 hours from when they get the information they need to make the decision. If your condition is so serious that 72 hours is too long, they have to make the decision sooner.

**Q: Can the insurance company stop my treatment if I'm in the hospital?**
A: The insurance company can't stop treatment recommended by your doctor until they talk to your doctor and figure out another plan your doctor agrees to. This applies to any concurrent review.

**Q: Will the insurance company tell me if they decide to change, delay or deny my doctor's request to treat me?**
A: Yes. The insurance company has to tell you and your doctor in writing, and state why they are changing, delaying or denying your treatment.

**Q: What if I disagree with the insurance company's decision?**
A: There are specific and strict timelines you must meet or you will lose important rights. You must object to the decision within 20 days of getting it. Once you do that, the insurance company will give you a qualified medical evaluator (QME) panel request form to submit to the Division of Workers' Compensation (DWC) Medical Unit. The DWC is writing more information on the subject of QME panels. Please check the Information and Assistance (I&A) guides in August 2005 or speak to an I&A officer for more information.

**Q: Is there any way to help make the utilization review go smoothly?**
A: Utilization review works best when your doctor stays in contact with the insurance company's doctor throughout the process. Your doctor must state the reasons for the treatment being requested when making the request. And if the insurance company's doctor asks for more information, your doctor should respond.

**Q: If I have completed the QME process and the insurance company is still denying the treatment, what do I do?**
A: You'll need to see a workers' compensation judge to get the disagreement resolved. File a declaration of readiness to proceed to expedited hearing to go before a judge. See I&A guide 7 for specific instructions. If you do not have an existing case open at the local WCAB office, you also need to file an application for adjudication of claim (see I&A guide 10), which opens a WCAB case for you.

**Q: What if more than 14 days have gone by since my doctor requested treatment and we haven't heard or received anything from the insurance company?**
A: If your doctor has not been able to get a response from the insurance company, file a declaration of readiness to proceed to expedited hearing. See above answer for more details.

If you need one of the I&A guides or other help, call an I&A office or attend a workshop for injured workers. The local I&A phone numbers are attached to this fact sheet. You can also get information on local workshops and download the guides from the Web at www.dir.ca.gov/dwc.



I&A fact sheet A
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# WORKERS' COMPENSATION APPEALS BOARD
# DISTRICT OFFICES

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1661 N. Raymond Ave., Suite 202
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1800 30th Street, Suite 100
Information & Assistance Unit **(661) 395-2514**

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100 "H" Street, Suite 202
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2550 Mariposa Street, Suite 4078
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Information & Assistance Unit **(530) 225-2047**

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2424 Arden Way, Suite 230
Information & Assistance Unit **(916) 263-2741**

**SALINAS, 93906-2204**
1880 North Main Street, Suites 100 & 200
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Information & Assistance Unit **(909) 383-4522**

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7575 Metropolitan Drive, Suite 202
Information & Assistance Unit **(619) 767-2170**

**SAN FRANCISCO, 94102-7002**
455 Golden Gate Avenue, 2nd Floor
Information & Assistance Unit **(415) 703-5020**

**SAN JOSE, 95113-1482**
100 Paseo de San Antonio, Suite 241
Information & Assistance Unit **(408) 277-1292**

**SANTA ANA, 92701-4070**
28 Civic Center Plaza, Suite 451
Information & Assistance Unit **(714) 558-4597**

**SANTA MONICA, 90405-5219**
2701 Ocean Park Blvd., Suite 220
Information & Assistance Unit **(310) 452-1188**

**SANTA ROSA, 95404-4760**
50 "D" Street, Suite 420
Information & Assistance Unit **(707) 576-2452**

**STOCKTON, 94202**
31 East Channel Street, Suite 344
Information & Assistance Unit **(209) 948-7980**

**VAN NUYS, 91401-3373**
6150 Van Nuys Blvd., Suite 105
Information & Assistance Unit **(818) 901-5374**

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